STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

September 9, 2021

Destiny Saucedo-Al Jallad
Turning Leaf Res Rehab Svcs., Inc.
P.O. Box 23218
Lansing, MI 48909

RE: License #: AL390392502
Investigation #: 2021A1030023
Birch Cottage II

Dear Ms. Saucedo-Al Jallad:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL390392504
Investigation #:	2021A1030023
Complaint Receipt Date:	07/15/2021
Investigation Initiation Date:	07/16/2021
Report Due Date:	09/13/2021
Licensee Name:	Turning Leaf Res Rehab Svcs., Inc.
Licensee Address:	621 E. Jolly Rd. Lansing, MI 48909
Licensee Telephone #:	(517) 393-5203
Administrator:	Destiny Saucedo-Al Jallad, Designee
Licensee Designee:	Destiny Saucedo-Al Jallad, Designee
Name of Facility:	Birch Cottage II
Facility Address:	13326 N. Boulevard St. Vicksburg, MI 49097
Facility Telephone #:	(269) 585-8762
Original Issuance Date:	11/14/2019
License Status:	REGULAR
Effective Date:	05/14/2020
Expiration Date:	05/13/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

ALLEGATION(S)

	Violation Established?
Resident A was not adequately supervised by direct care staff.	Yes
Additional Findings	Yes

II. METHODOLOGY

07/15/2021	Special Investigation Intake 2021A1030023
07/16/2021	Special Investigation Initiated - On Site
07/16/2021	Contact - Document Received- Documents received and reviewed
07/16/2021	Contact - Face to Face- Interview with Karen Gill
07/16/2021	Contact - Telephone call made- Interview with Zeta Francosky
07/16/2021	Contact - Document Received- Email received from Zeta Francosky
07/21/2021	Contact - Telephone call made- Interview with Josh Dill
07/26/2021	Contact - Telephone call made- Interview with Phillip Carson
07/26/2021	Contact - Telephone call made- Interview with Kayla Jackson
07/27/2021	Contact - Telephone call made- Interview with Lisa Holland
08/23/2021	Exit Conference with Licensee Designee by phone.
08/27/2021	Contact- Teams meeting – Teams meeting with Dawn Timm, Destiny Saucedo- Al-Jallad, Sami Al-Jallad and Zeta Francosky

ALLEGATION:

Resident A was not adequately supervised by direct care staff.

INVESTIGATION:

On 07/16/2021, I conducted an on-site investigation at Turning Leaf AFC. I interviewed Program Manager, Angie Bloemsma regarding the allegation. Ms. Bloemsma reported she was not working when Resident A left the facility and was later located in Grand Rapids. Ms. Bloemsma reported Resident A is her own guardian and manages her own

money. Ms. Bloemsma reported Resident A leaves the facility daily for walks or to the Speedway Gas Station and, until 7/14/2021, always came back in an hour or two. Ms. Bloemsma reported the facility asks the residents to sign in and out, including Resident A, however Resident A did not sign out the final time she left the facility on 07/14 and did not return. I reviewed the sign out log and noted that Resident A signed in and out earlier in the day on 07/14 but did not sign out later after 5PM. Ms. Bloemsma reported she is unaware of the exact time Resident A left the facility and what time it was discovered she was gone and law enforcement was contacted. Ms. Bloemsma reported they did try to locate Resident A by driving around Vicksburg and Kalamazoo but could not find her. Ms. Bloemsma reported there is no specific policy on how often they check on the residents. Ms. Bloemsma reported there were two direct care staff members working (Kayla Jackson and Phillip Carson) during the shift that Resident A left the facility. Ms. Bloemsma reported there were 12 residents in Birch Cottage II. Ms. Bloemsma reported Resident A suffers from mental illness and has been refusing to take her medications for the last two weeks and has been more “dysregulated” for the last one and half to two weeks. Ms. Bloemsma reported the facility filed for guardianship due to their concerns about Resident’s A ability to make decisions.

On 07/16/2021, I received and reviewed Resident A’s *Assessment Plan for AFC Residents* (assessment plan) dated 04/07/2020, *Medication Administration Record* (MAR) for July 2021, *AFC Resident Care Agreement (RCA)* dated 04/07/2020, *Person-Center Plan* (PCP) dated 05/03/2021, *Psychosocial Assessment* (PA)dated 05/10/2021, *Health Care Appraisal* dated 02/23/2021 and a petition for guardianship involving Resident A dated 05/11/2021.

Resident A’s assessment plan indicated she is “highly delusional” and continues to leave without notifying staff.” Resident A’s MAR indicated she stopped taking any oral medication on 07/08/2021, however was still receiving her bi-weekly Haloperidol injection. Resident A’s PCP indicated Resident A “enjoys walking and staff should know when she leaves the cottage. Staff will have Resident A sign out and know when she will sign back in.” Resident A’s *psychological assessment* indicated she “presents with symptoms of psychosis that include fixed delusions of grandeur.” The petition for guardianship indicated Resident A’s need for guardianship is based in part on “lack of insight to her illness and danger unawareness.”

On 07/16/2021, I interviewed Health Care Coordinator, Karen Gill regarding the allegations. Ms. Gill reported Resident A had been dysregulated and “non-complaint with medication.” Ms. Gill reported Resident A was in the courtyard at 5:45pm and could not be located for medications at 7:30pm. Ms. Gill reported the direct care staff alerted police when they could not locate Resident A.

On 07/16/2021, I spoke with Program Director Zeta Francosky regarding the investigation. Ms. Francosky reported she moved Resident A from one of their facilities in Grand Rapids in April 2020 because she was unable to follow Covid-19 safety protocols. Ms. Francosky reported Resident A was located in Grand Rapids on 07/15/2021 and was with a family member. Ms. Francosky reported Resident A was

informed a direct care staff would be picking her up and bringing her back to Turning Leaf Birch Cottage II. Ms. Francosky reported Resident A refused to return and left her family member's home. Ms. Francosky reported the police are looking for her and will contact Ms. Francosky when she is located.

On 07/16/2021, I received a forwarded email that was sent to Cathy Cushman from Zeta Francosky. The emailed indicated that Resident A was located and will be taken to Silver Maple Home in Grand Rapids as she is still refusing to return to Turning Leaf Birch Cottage II in Vicksburg.

On 07/21/20201, I spoke with Karen Gill to follow up on mental health services being provided to Resident A. Ms. Gill reported Resident A's services through Interact of Grand Rapids closed and were not transferred to Interact of Kalamazoo. Ms. Gill reported Turning Leaf asked for her services to be transferred but they (Interact of Grand Rapids) did not complete the transfer. Ms. Gill denied knowing the reason the case was not transferred. Ms. Gill reported Resident A was received "in house" mental health services.

On 07/21/2021, I interviewed Josh Dill from Interact of Grand Rapids. Mr. Dill is the supervisor of the ACT Delta Team and worked with Resident A while she lived in Kent County. Mr. Dill reported that "to the best of my recollection" there was a "freeze on ACT intakes" when Resident A first moved to Kalamazoo County. Mr. Dill reported Interact explored filing a petition for guardianship while Resident A was receiving services as she is "pretty delusional at baseline" however she moved before they were able to complete the process. Mr. Dill reported the staff from Turning Leaf- Birch Cottage II indicated Resident A would receive mental health services through their clinicians.

On 07/26/2021, I spoke with Phillip Carson regarding the allegations. Mr. Carson reported he was not working on 07/14/2021 and was unable to answer any direct questions about the situation.

On 07/26/2021, I interviewed Kayla Jackson regarding the allegations. Ms. Jackson reported she was working on 07/14/2021 and was working alone. Ms. Jackson reported she usually works second shift by herself. Ms. Jackson reported there were 11 residents. Ms. Jackson reported it is difficult for one person to manage 11 residents when some of the residents are having "behaviors" and on the date in question, Ms. Jackson stated she was having a tough day managing behaviors in the facility. Ms. Jackson reported Resident A takes walks daily. Ms. Jackson reported she thinks Resident A went out for a walk at about 5:00pm but Ms. Jackson stated she did not realize Resident A had not come back until she was passing medication at about 7:30pm. Ms. Jackson reported when she figured out Resident A was gone, she contacted the Vicksburg Police Department. Ms. Jackson reported direct care staff member Lisa Holland from Birch Cottage I went driving around looking for Resident A.

On 07/27/2021, I interviewed Turning Leaf Birch Cottage I direct care staff member, Lisa Holland regarding the allegations. Ms. Holland reported she was working in Birch Cottage I on 07/14/2021 when Resident A left the facility. Ms. Holland reported she was on her side of the building when direct care staff member Kayla Jackson asked her about Resident A. Ms. Holland reported Ms. Jackson was passing medication at 8:00pm and could not find Resident A. Ms. Holland reported that earlier that shift Ms. Jackson was responding to residents that were having behaviors as one of them tried to elope by going out of the gate in the courtyard. Ms. Holland reported an alarm went off and Ms. Jackson responded. Ms. Holland reported Resident A was in the courtyard smoking and left the courtyard through the gate. Ms. Holland reported Resident A often went for walks, so it was not unusual for her to be seen walking outside of the courtyard. Ms. Holland reported Ms. Jackson was cooking dinner when this occurred around 5:00pm. Ms. Holland reported she called her supervisor after they discovered that Resident A was not in the building and was instructed to call the police. Ms. Holland reported she loaded up several residents in a company van and went to search for Resident A but could not find her.

On 08/27/2021, a Microsoft-Teams meeting was conducted to discuss status of the investigation at the request of licensee designee Sami Al-Jallad. The meeting included Area Manager, Dawn Timm, Licensee Designees, Destiny Saucedo-Al Jallad and Sami Al-Jallad and Program Manager Zeta Francosky. A timeline of events was provided by Ms. Francosky regarding Resident A's elopement on 07/14/2021. Ms. Francosky reported that according to the direct care staff, Resident A walked out of the gate in the courtyard somewhere between 5:30pm and 5:45pm. Ms. Francosky reported direct care staff member Kayla Jackson responded to the courtyard after a different resident opened the door to elope thus setting off the alarm. Ms. Francosky further reported the gate alarm was shut off and reset before the gate had been fully closed thereby making it possible for Resident A to elope from the courtyard without the alarm going off again. Ms. Francosky reported direct care staff member Lisa Holland made eye contact with Resident A as she was walking around the outside of the building and assumed she would be coming in one of the other doors, unfortunately instead Resident A eloped and was later located in Grand Rapids, MI. Ms. Francosky reported Ms. Jackson was unaware that Resident A had eloped until she passed evening medication between 7:15pm and 7:30pm at which time she began to search for Resident A.

On 08/30/2021, I made an on-site investigation to Turning Leaf Birch Cottage II and spoke with Zeta Francosky to obtain some additional information. Ms. Francosky reported Resident A was on a treatment order through Interact in Grand Rapids, MI but the order lapsed. AFC facility administrative staff completed the petition for guardianship, but it was never filed with the court because their attorney does not handle that sort of a case and Interact discharged Resident A when she moved to Vicksburg, MI. Ms. Francosky reported she did not contact Adult Protective Services regarding having a guardian appointed. Ms. Francosky reported Resident A refused medications at different time during her time in Birch II. Ms. Francosky reported they did contact her physician when she refused however did not have the documentation during the on-site visit. Ms. Francosky reported she will email me the correspondence

with her Visiting Physician. Ms. Francosky reported the majority of medications were vitamins and she tried to have them changed to PRN instead of daily medications.

I inspected the door in the courtyard that leads to the outside of the facility as it was reported that was how Resident A eloped for the facility on July 14, 2021. Ms. Francosky demonstrated that the door is locked from the outside but there is a delayed response when the door is opened from the inside and an alarm goes off. Ms. Francosky then demonstrated how to deactivate the alarm with a button in the medication room. To re-activate the alarm, the button gets pushed again, however the door does not need to be completely closed thereby allowing someone to leave the courtyard without the alarm going off. This is the sequence that occurred when Resident A eloped as Kayla Jackson responded as another resident attempted to elope.

On 08/30/2021, I received and reviewed Resident A *Medication Administration Record* (MAR) for April 2021, May 2021, and June 2021. The MARs indicated that Resident A refused to take Vitamin A, Vitamin D-3, and Vitamin E for the majority of months. The MARs for each month indicated the vitamins were "suspended, working with VPA to get vitamins that meet resident needs."

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on my investigation which included my personal observations of the facility, review of Resident A's *Assessment Plan for AFC Residents*, *Medication Administration Record*, *AFC Resident Care Agreement*, *Person-Center Plan*, *Psychosocial Assessment*, *Health Care Appraisal*, petition for guardianship, interviews with direct care staff members Phillip Carson, Kayla Jackson, Lisa Holland, program manager, Angie Bloemsma, health care coordinator, Karen Gill and program director/administrator Zeta Francosky this violation will be established. On 07/14/2021, Resident A left the Birch Cottage II without the knowledge of direct care staff member, Kayla Jackson, and without signing out or telling Ms. Jackson where she was going or when she would be back. Further, Ms. Jackson did not take additional steps to assure the alarmed gate in the courtyard was fully secured after it was opened by another resident thus allowing Resident A an undetected means of leaving the facility. Resident A's *Person Centered Plan* indicated that "staff will have Resident A sign out and know when she will sign back in." In addition, Resident A's assessment plan documented that she is "highly delusional and continues to leave without notifying staff." Consequently, Resident A was not provided with supervision as outlined in her Person Centered Plan which the facility agreed to provide.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/16/2021, I conducted an on-site investigation at Turning Leaf Birch Cottage II and spoke with Program Manager, Angie Bloemsma. I reviewed Resident A's file including her *Assessment Plan for AFC Residents* (assessment plan) and noted Resident A's assessment plan was dated 04/07/2020. Ms. Bloemsma reported the assessment plan located in Resident A's file was the most current version.

On 08/30/2021, I spoke with program director, Zeta Francosky regarding Resident A's *Assessment Plan for AFC Residents*. Ms. Francosky acknowledged the AP was overdue.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	During an on-site investigation on 07/16/2021, I reviewed Resident A's *Assessment Plan for AFC Residents* which was dated 04/07/2020 and was the most current version. The document had not been updated annually as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 07/16/2021, I conducted an on-site investigation at Turning Leaf Birch Cottage II and spoke with Program Manager, Angie Bloemsma. I reviewed Resident A's file including her *Resident Care Agreement* (RCA) and noted the RCA was dated 04/07/2020. Ms. Bloemsma reported the AP located in Resident A's file is the most current version of the RCA.

On 08/30/2021, I spoke with program director, Zeta Francosky regarding Resident A's *Resident Care Agreement* (RCA.) Ms. Francosky acknowledged the RCA was overdue.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designed representative and responsible agency, if applicable, at least annually or more often if necessary.

ANALYSIS:	During an on-site investigation on 07/16/2021, I reviewed Resident A's *Resident Care Agreement* which was dated 04/07/2020 which indicates the document was not updated annually.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Based on an acceptable correction action plan, I recommend no change in the current license status.

Nile Khabeiry, LMSW 09/03/2021

Nile Khabeiry Date
Licensing Consultant

Approved By:

Dawn Timm 09/09/2021

Dawn N. Timm Date
Area Manager